
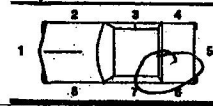


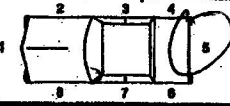
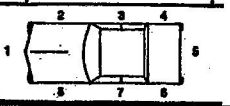
OHIO TRAFFIC CRASH REPORT

OH-1 (Rev. 1-82)

LOCAL REPORT NO. 14-8703		<input type="checkbox"/> OH-2 <input type="checkbox"/> OH-3		Lebanon Police		0830300		ODHS USE ONLY - 00 NOT MARK ABOVE				LOCAL FILE NO.					
REPORT TAKEN <input type="checkbox"/> AT STATION <input checked="" type="checkbox"/> AT SCENE	NO OF VEH PEDESTRIANS INVOLVED 3		CRASH SEVERITY (CHECK MOST SEVERE) <input type="checkbox"/> FATAL <input type="checkbox"/> INJURY <input checked="" type="checkbox"/> PROPERTY DAMAGE ONLY			COMBINED VEH/PROP LOSS <input checked="" type="checkbox"/> OVER \$150 <input type="checkbox"/> UNDER \$150		HIT SKIP <input type="checkbox"/> SOLVED <input type="checkbox"/> UNSOLVED									
IN COUNTY OF WARREN				IN <input checked="" type="checkbox"/> CITY		LEBANON		DATE OF CRASH: DAY 05 12 14 Friday		TIME: MILITARY 1134							
CRASH OCCURRED ON Colony Square Parking Lot				WITHIN THE INTERSECTION OF Colony Square Parking Lot													
IF NOT IN INTERSECTION				(LIST NEAREST INTERSECTING STREET, MILEPOST, HOUSE NO.)									CITY CODE 8303				
MILES 500 FEET W N E S OF Dove Ave.																	
LOC JUR FH9 FILT																	
A UNIT NO. 1				NO OF OCCUPANTS 1		OPERATING <input checked="" type="checkbox"/> PARKED <input type="checkbox"/> DRIVERLESS <input type="checkbox"/> HIT & RUN NON CONTACT <input type="checkbox"/>		INSURANCE CO OR AGENT NATION WIDE		9231K747009							
DRIVER/PEDESTRIAN NAME (LAST, FIRST, MI) Michaelis chelsea Lynn				ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) 367 2nd St. Morrow OH 45152													
PHONE NO. 583-382-8360		BIRTH DATE 9/27/95		AGE 17		SEX F		SOCIAL SECURITY NO.		STATE OH			DRIVER'S LICENSE NO. UA733794		OCCUPATION NA		
OWNER (IF SAME AS DRIVER, WRITE SAME) SAME				ADDRESS SAME								PHONE SAME					
VEH YR 1997		MAKE GMC		MODEL Truck		COLOR GRN		STYLE TRK		STATE OH		LICENSE PLATE NO. FFC1861		TOWING SERVICE NA		VEH/PED DIR FROM W TO E	
CIRCLE DAMAGE AREAS 		9 TOP 10 UNDER CAR 11 LOAD 12 TRAILER		DAMAGE SEVERITY <input type="checkbox"/> NON-FUNCTIONAL <input type="checkbox"/> FUNCTIONAL <input checked="" type="checkbox"/> DISABLING		DAMAGE SCALE <input type="checkbox"/> NONE <input type="checkbox"/> MODERATE <input type="checkbox"/> LIGHT <input checked="" type="checkbox"/> HEAVY		VEHICLE DISPOSITION <input type="checkbox"/> DRIVEN AWAY <input type="checkbox"/> REMAINED AT SCENE <input checked="" type="checkbox"/> TOWED		FIRE <input checked="" type="checkbox"/> NO FIRE <input type="checkbox"/> FIRE DUE TO CRASH <input type="checkbox"/> OTHER FIRE							
8 UNIT NO. 2		NO OF OCCUPANTS 1		OPERATING <input checked="" type="checkbox"/> PARKED <input type="checkbox"/> DRIVERLESS <input type="checkbox"/> HIT & RUN NON-CONTACT <input type="checkbox"/>		INSURANCE CO. OR AGENT Progressive		215143190									
DRIVER/PEDESTRIAN NAME (LAST, FIRST, MI) Potter Ronnie				ADDRESS (NO., STREET, CITY, STATE, ZIP CODE) 352 Milam Dr. A So. Lebanon OH 45065													
PHONE NO.		BIRTHDATE 11/13/91		AGE 21		SEX M		SOCIAL SECURITY NO.		STATE OH		DRIVER'S LICENSE NO. TP206900		OCCUPATION NA			
OWNER (IF SAME AS DRIVER, WRITE SAME) SAME				ADDRESS SAME								PHONE SAME					
VEH YR 2001		MAKE Ford		MODEL 2D		COLOR yel		STYLE 2D		STATE OH		LICENSE PLATE NO. 6B16ROWN		TOWING SERVICE None		VEH/PED DIR FROM S TO N	
CIRCLE DAMAGE AREAS 		9 TOP 10 UNDER CAR 11 LOAD 12 TRAILER		DAMAGE SEVERITY <input type="checkbox"/> NON-FUNCTIONAL <input checked="" type="checkbox"/> FUNCTIONAL <input type="checkbox"/> DISABLING		DAMAGE SCALE <input type="checkbox"/> NONE <input checked="" type="checkbox"/> MODERATE <input type="checkbox"/> LIGHT <input type="checkbox"/> HEAVY		VEHICLE DISPOSITION <input checked="" type="checkbox"/> DRIVEN AWAY <input type="checkbox"/> REMAINED AT SCENE <input type="checkbox"/> TOWED		FIRE <input checked="" type="checkbox"/> NO FIRE <input type="checkbox"/> FIRE DUE TO CRASH <input type="checkbox"/> OTHER FIRE							
C FROM UNIT NO.		NAME (LAST, FIRST, MI)		BIRTHDATE		AGE		POSITION		INJURIES							
		ADDRESS		PHONE		SEX		A B C D E F		A B C D E F							
D FROM UNIT NO.		NAME (LAST, FIRST, MI)		BIRTHDATE		AGE											
		ADDRESS		PHONE		SEX											
E FROM UNIT NO.		NAME (LAST, FIRST, MI)		BIRTHDATE		AGE											
		ADDRESS		PHONE		SEX											
F FROM UNIT NO.		NAME (LAST, FIRST, MI)		BIRTHDATE		AGE											
		ADDRESS		PHONE		SEX											
A B C		INJURED TAKEN TO		By				A B C D E F		ALCOHOL							
D E F		INJURED TAKEN TO		By				A B C D E F		A B C D E F							
A B C		OFFENSE CHARGED AND DESCRIPTION						1 NOT USED 2 NONE AVAILABLE 3 LAP BELT USED 4 LAP/SHOULDER BELT USED 6 SHOULDER BELT USED 7 CHILD SAFETY SEAT 8 USE NOT REPORTED		1 NO ALCOHOL DETECTED 2 HBD ABILITY IMPAIRED 3 HBD ABILITY NOT IMPAIRED 4 HBD ABILITY UNKNOWN							
D E F		OFFENSE CHARGED AND DESCRIPTION						EJECTION		DRUGS							
A B C		RECEIVED CALL 1134		DISPATCHED 1136		ARRIVED 1141		CLEARED 1201		OTHER TIME 0010		TOTAL MINUTES 37					
D E F		DATE REPORT FILED M 6/11/14		PHOTOS YES NO		OFFICER'S NAME N. Trout		BADGE NO. 129		CHECKED BY							
A B C		1 NOT EJECTED 2 PARTIAL 3 TOTAL 4 TRAPPED INSIDE VEHICLE						A B C D E F		A B C D E F							
D E F		1 NO DRUGS DETECTED 2 USING PRESCRIBED DRUG 3 USING ILICIT DRUG															

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REPORT TAKEN <input type="checkbox"/> AT STATION <input checked="" type="checkbox"/> AT SCENE	NO OF VEH PEDESTRIANS INVOLVED 3		CRASH SEVERITY (CHECK MOST SEVERE) <input type="checkbox"/> FATAL <input type="checkbox"/> INJURY <input checked="" type="checkbox"/> PROPERTY DAMAGE ONLY			COMBINED VEH/PROP LOSS <input checked="" type="checkbox"/> OVER \$150 <input type="checkbox"/> UNDER \$150		HIT SKIP <input type="checkbox"/> SOLVED <input type="checkbox"/> UNSOLVED					
IN COUNTY OF WARREN			IN <input checked="" type="checkbox"/> CITY LEBANON			DATE OF CRASH: 5/3/14 Friday		TIME: MILITARY 1134					
CRASH OCCURRED ON Colony Square Parking Lot			WITHIN THE INTERSECTION OF Colony Square Parking Lot			LIST NEAREST INTERSECTING STREET, MILEPOST, HOUSE NO. Dove Ave			CITY CODE 8303				
IF NOT IN INTERSECTION _____ MILES _____ FEET W _____ S _____ OF _____													
A UNIT NO. 3		NO OF OCCUPANTS 0		OPERATING <input type="checkbox"/>		PARKED <input checked="" type="checkbox"/>		DRIVERLESS <input type="checkbox"/>			HIT & RUN NON CONTACT <input type="checkbox"/>	INSURANCE CO OR AGENT Gibbs Assoc. BAP2355082	
DRIVER-PEDESTRIAN NAME (LAST, FIRST, MI)				ADDRESS (NO., STREET, CITY, STATE, ZIP CODE)									
PHONE NO.		BIRTH DATE m y		AGE 		SEX 		SOCIAL SECURITY NO.			STATE	DRIVER'S LICENSE NO.	OCCUPATION
OWNER (IF SAME AS DRIVER, WRITE SAME) Rent-to-own				ADDRESS 726 E. Main St. Lebanon OH 45036							PHONE 934-4355		
VEH YR 2012	MAKE Chevy	MODEL TRK	COLOR BLK	STYLE TRK	STATE OH	LICENSE PLATE NO. PHT 4236	TOWING SERVICE	VEH/PED DIR FROM E TO W					
CIRCLE DAMAGE AREAS 		9 TOP 10 UNDER CAR 11 LOAD 12 TRAILER		DAMAGE SEVERITY <input checked="" type="checkbox"/> NON-FUNCTIONAL <input type="checkbox"/> FUNCTIONAL <input type="checkbox"/> DISABLING		DAMAGE SCALE <input type="checkbox"/> NONE <input checked="" type="checkbox"/> MODERATE <input type="checkbox"/> LIGHT <input type="checkbox"/> HEAVY		VEHICLE DISPOSITION <input type="checkbox"/> DRIVEN AWAY <input checked="" type="checkbox"/> REMAINED AT SCENE <input type="checkbox"/> TOWED		FIRE <input checked="" type="checkbox"/> NO FIRE <input type="checkbox"/> FIRE DUE TO CRASH <input type="checkbox"/> OTHER FIRE			
8 UNIT NO.		NO OF OCCUPANTS		OPERATING <input type="checkbox"/>		PARKED <input type="checkbox"/>		DRIVERLESS <input type="checkbox"/>		HIT & RUN NON-CONTACT <input type="checkbox"/>		INSURANCE CO. OR AGENT	
DRIVER/PEDESTRIAN NAME (LAST, FIRST, MI)				ADDRESS (NO., STREET, CITY, STATE, ZIP CODE)									
PHONE NO.		BIRTHDATE m D y		AGE 		SEX 		SOCIAL SECURITY NO.		STATE	DRIVER'S LICENSE NO.	OCCUPATION	
OWNER (IF SAME AS DRIVER, WRITE SAME)				ADDRESS						PHONE			
VEH YR	MAKE	MODEL	COLOR	STYLE	STATE	LICENSE PLATE NO.	TOWING SERVICE	VEH/PED DIR FROM TO					
CIRCLE DAMAGE AREAS 		9 TOP 10 UNDER CAR 11 LOAD 12 TRAILER		DAMAGE SEVERITY <input type="checkbox"/> NON-FUNCTIONAL <input type="checkbox"/> FUNCTIONAL <input type="checkbox"/> DISABLING		DAMAGE SCALE <input type="checkbox"/> NONE <input type="checkbox"/> MODERATE <input type="checkbox"/> LIGHT <input type="checkbox"/> HEAVY		VEHICLE DISPOSITION <input type="checkbox"/> DRIVEN AWAY <input type="checkbox"/> REMAINED AT SCENE <input type="checkbox"/> TOWED		FIRE <input type="checkbox"/> NO FIRE <input type="checkbox"/> FIRE DUE TO CRASH <input type="checkbox"/> OTHER FIRE			
C FROM UNIT NO.	NAME (LAST, FIRST, MI)			BIRTHDATE m D y		AGE	POSITION A B C D E F			INJURIES A B C D E F			
ADDRESS SAME				PHONE		SEX							
D FROM UNIT NO.	NAME (LAST, FIRST, MI)			BIRTHDATE m D y		AGE	POSITION A B C D E F			INJURIES A B C D E F			
ADDRESS				PHONE		SEX							
E FROM UNIT NO.	NAME (LAST, FIRST, MI)			BIRTHDATE m D y		AGE	POSITION A B C D E F			INJURIES A B C D E F			
ADDRESS				PHONE		SEX							
F FROM UNIT NO.	NAME (LAST, FIRST, MI)			BIRTHDATE m D y		AGE	POSITION A B C D E F			INJURIES A B C D E F			
ADDRESS				PHONE		SEX							
A B C	INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED				
D E F	INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED				
A	OFFENSE CHARGED AND DESCRIPTION			ORC CITY ORD.		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED				
D	OFFENSE CHARGED AND DESCRIPTION			ORC CITY ORD.		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED				
RECEIVED CALL 1134		DISPATCHED 1136		ARRIVED 1141		CLEARED 1201		OTHER TIME 0010		TOTAL MINUTES 37			
DATE REPORT FILED 6/10/14		PHOTOS YES NO		OFFICER'S NAME N. Trout		BADGE NO. 124		CHECKED BY					
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
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A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
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A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
A B C		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
D E F		INJURED TAKEN TO			By		A B C D E F			ALCOHOL A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED			
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